Comments on Interim Charge 1: SB 1940

Texas House Committee on Insurance

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The Foundation for Government Accountability (FGA) is a nonprofit, nonpartisan organization that seeks to improve the lives of Americans. FGA's work has included extensive work on health care reform in numerous states, including on reinsurance issues. We wanted to offer some thoughts related to SB 1940 as the state considers a pathway forward.

In order for Texas to remain a destination for entrepreneurs and those who are self-employed as part of the telecommuting economy, we affirm that Texas needs to take steps to heal the broken individual insurance market.

Texas has multiple policy options to make health insurance more affordable and to expand access to primary and specialty care. The state should expand access to copper plans, split the single risk pool, and expand access to plans that wrap around direct health care agreements.

These reforms will produce plans with significantly lower premiums. They will expand access to more high-quality care in rural areas, including primary care, mental health, and specialists. These reforms will also allow providers to spend more time with their patients and help those with chronic conditions get healthier more quickly, driving down spending and premiums in the future.

With these changes, Texas's individual market will improve without a government bailout. The result will be more affordable options for those that want to live and work in the state.

Expensive premiums are driving people out of the individual market

Even pre-COVID, enrollment was decreasing. Between 2016 and 2018, the number of people buying unsubsidized plans in the individual market dropped by a startling 57 percent in Texas.[1]

Nearly 255,000 fewer Texans are now buying individual market coverage than just a few short years ago.S[2] As premiums continue to rise, and finances are tight for some, more enrollees will continue to flee the market, causing a never-ending, reinforcing cycle of higher premiums and fewer enrollees.

Texas's individual market could improve with just a few steps

New federal rules on Health Reimbursement Arrangements (HRAs) can be a game-changer for small companies. For the first time ever, small businesses can empower their employees to enter the individual market and purchase the plan that is right for their family with tax-advantaged dollars.[3] This will be especially important in Texas, where fewer than 30 percent of small businesses are offering health insurance coverage to their employees.[4]

This is an opportunity to increase private health insurance coverage, but also stabilize the individual market. However, increasing premiums threaten to minimize the massive potential this rule might otherwise have. Many employers will be hesitant to send their employees to an individual market with growing premiums and a shrinking enrollment base.

By ensuring more affordable options are made available, Texas can reset the foundation of the individual market, attract new healthy enrollees into the individual market, and draw back in many who have dropped out, breaking the downward cycle of the individual market. Four additional ideas could improve Texas's planning process and any potential waiver request.

Texas can expand access to Copper plans

Under ObamaCare/ACA, the individual market has four "tiers" of plans, based on cost-sharing levels. Platinum plans have the lowest cost-sharing and thus typically have the highest premiums. Catastrophic plans, also known as Copper plans, have the highest cost-sharing and usually have the lowest premiums. Because government subsidies cannot be used to pay for Copper plans, they also have their own, separate risk pool, which is significantly healthier than the subsidized market.

However, these plans are currently only available to individuals who are under age 30 or who otherwise meet hardship criteria. Texas could seek a waiver to increase access to these plans to more people, providing potential enrollees with greater choices. It could allow individuals in their 30s and 40s to access these plans, with the maximum age set at the level determined by actuaries as necessary to ensure the greatest premium relief.

The average premiums for Copper plans in Texas are roughly 10 percent lower than average premiums for Bronze plans, and 33 percent lower than average Silver plan premiums.[5] While allowing slightly older enrollees into the Copper plan market could somewhat moderate these premium savings, finding the right age cutoff will ensure that premiums are still significantly more affordable.

A waiver proposal could increase the age of those that can access cooper plans, but make these plans available only off-exchange, to avoid the added expense of building an ObamaCare exchange or reimbursing the federal government for a custom IT build of Healthcare.gov.

Texas can split the risk pool to lower premiums off-exchange

Under ObamaCare/ACA, all consumers in the individual market, on- and off-exchange, are grouped into the same risk pool. However, those buying coverage on HealthCare.gov are significantly more expensive to cover, driving up premiums for those buying coverage directly from insurers. Those buying plans on the exchange have risk scores that are 25 percent higher than those buying off-exchange.[6]

While those receiving subsidies have been insulated against skyrocketing premiums in the deteriorating individual market, those paying the full cost of their premiums have suffered most. Splitting the risk pool would allow for significant premium relief for those buying off-exchange, attracting additional enrollees back into the individual market. Because over 91 percent of Texas exchange enrollees receive subsidies, this would have little effect on exchange enrollees' net premium costs.[7] The remaining nine percent of Texas exchange enrollees who do not receive subsidies could move off-exchange to take full advantage of the premium savings other off-exchange enrollees would see.

Splitting the risk pool could also spur more employers to take advantage of the new HRA rule. Under the new rule, employers can provide tax-free dollars to employees to buy individual coverage. In order for individuals to pay the difference between their employers' HRA contributions and total premiums with tax-advantaged dollars, they must purchase off-exchange. They could then have the difference deducted from their paycheck on a pre-tax basis through a section 125 plan.

But many employers may be unwilling to adopt this HRA option, and many employees may be reluctant to take it up, if their premiums are driven heavily by on-exchange enrollees. In Texas, the average risk score in the individual market—driven virtually entirely by subsidized on-exchange enrollees—is roughly 17 percent higher than the average risk score in the current small group market.[8] By splitting the risk pool, Texas could ensure the small group market and off-exchange market had similar risk scores, enticing more employers to take advantage of the new HRA flexibility.

Lower premiums off-exchange could also induce individuals with small and moderate subsidy levels to shift out of the exchange, thereby reducing costs to taxpayers. Additionally, it could encourage more small companies to take advantage of the new HRA flexibility, empowering their employees to move into the individual market. For those who currently offer employer-based insurance, the switch to the off-exchange individual market could mean lower premiums for employees and higher wages, thereby resulting in some additional tax revenues to offset any subsidy costs for changes to those left on the exchange. For those not offering coverage today, employers would be sending more healthy lives to the individual market to spread risk and lower premiums. Finally, if any employees are currently on Medicaid, this change could result in savings if their employer starts to offer an HRA and the employee moves to the off-exchange market.

Texas should consider splitting the risk pool altogether to maximize the effectiveness of such a policy change.

Texas can allow more plans to wrap around direct medical care arrangements

Direct Medical Care (DMC) arrangements have enormous potential to lower costs and provide high-quality care, especially for those remaining in the individual market. DMCs build off the success of the direct primary care (DPC) model that has been shown to deliver high-value care and save money in the process. These arrangements can increase access in rural areas, as it is easier for practices to thrive with small patient panels and virtual DMC arrangements are becoming more and more prevalent nationwide.

As DPCs can provide the vast majority of care for most patients, and other DMC arrangements can be added as needed, a waiver offers the opportunity to introduce products onto the market that wrap around these agreements. As a result, the plans will cost far less as they will be reserved for only major medical events.

Wrapping lower premium coverage plans around DMC could also remove perverse incentives that currently lead to billions of dollars in unnecessary treatment. This system would challenge the wildly inefficient and costly way that most health care is delivered now. Allowing consumers to pair DMC arrangements with health plans that wraparound DMC services would give Texans more affordable options to consider.

Texas could utilize invisible risk-sharing as its reinsurance model

SB 1940 considers starting a temporary health insurance risk pool. Some states, like Maine, have had success in reducing premiums by setting up a prospective condition-based reinsurance—often called invisible risk-sharing or an invisible high risk pool.[9] This allows reinsurance money to be more efficiently deployed when compared to other approaches. It maximizes premium reduction and does not segment out those with specific conditions but keeps everyone in the individual market on the same type of plans. In addition, risk-sharing requires insurers to better manage enrollees upfront, as they are on the hook for certain costs in the future if the individual is not part of the invisible risk program.

The benefit of such an approach can lead to lower and more stable premiums and can attract younger enrollees based on the resulting lower premiums. This approach also protects those with pre-existing conditions and allows them access to coverage, while lowering premiums for others in the market. If Texas splits the risk pool, public resources would be maximized if invisible risk-sharing was targeted to off-exchange plans.

Thank you for your consideration of these ideas on this important issue. FGA stands ready to assist in any follow

up conversations related to these ideas as Texas considers the best pathway forward to help those that are hurting in the individual market.

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1 Authors' calculations based upon data provided by the U.S. Department of Health and Human Services on individual market enrollment between 2016 and 2018, disaggregated by subsidy status. See, e.g., Centers for Medicare and Medicaid Services, "Trends in subsidized and unsubsidized enrollment," United States Department of Health and Human Services (2019), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf.
2 Ibid.
3 Internal Revenue Service, "Health Reimbursement Arrangements and other account-based group health plans," U.S. Department of the Treasury (2019), https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf.
4 Authors' calculations based upon data provided by the U.S. Department of Health and Human Services on the health insurance offer rate at firms with fewer than 50 employees. See, e.g., Agency for Healthcare Research and Quality, "Percent of private-sector establishments that offer health insurance by firm size and State: 2018," U.S. Department of Health and Human Services (2019), https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2018/tiia2.pdf.
5 Authors' calculation based upon data provided by the U.S. Department of Health and Human Services on plan-level premiums, disaggregated by county and plan tier. See, e.g., Centers for Medicare and Medicaid Services, "2020 QHP choice and premiums in Healthcare.gov states: Landscape file," U.S. Department of Health and Human Services (2019), https://www.healthcare.gov/health-plan-information-2020.
6 Author's calculations based upon data provided by the U.S. Department of Health and Human Services on average risk scores for Silver plan enrollees on and off exchange. See, e.g., Centers for Medicare and Medicaid Services, "Summary report on permanent risk adjustment transfers for the 2017 benefit year," U.S. Department of Health and Human Services (2018), https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.
7 Centers for Medicare & Medicaid Services, "First half of 2019 average effectuated enrollment data," U.S. Department of Health & Human Services, (2019), https://www.cms.gov/files/document/effectuated-enrollment-first-half-2019. Preliminary unadjusted date from early 2020 shows an even higher rate qualifying for subsidies.
8 Author's calculations based upon data provided by the U.S. Department of Health and Human Services on average risk scores for plans in the individual and small group markets in Texas. See, e.g., Centers for Medicare and Medicaid Services, "Summary report on permanent risk adjustment transfers for the 2017 benefit year: Appendix A, HHS risk adjustment program state-specific data," U.S. Department of Health and Human Services (2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-2017-Summary-Report-Data.xlsx.
9 Joel Allumbaugh, Tarren Bragdon, Josh Archambault, "Invisible High-Risk Pools," Health Affairs, (2017), https://www.healthaffairs.org/do/10.1377/hblog20170302.059003/full/